STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a, building 00			COMPL	COMPLETED		
				B. WING 10/04/2013			2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER							
BRIDGE	AT GARDEN PLAZ	Δ	8614 W 10TH ST INDIANAPOLIS, IN 46234					
				<u> </u>	Al OLIO, IN 40204			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
R000000								
	This visit was for Survey.	or a State Licensure	R00	00000				
	- - -							
		esidential findings were ance with 410 IAC						
	Dates of Surve	y: October 3 and 4,						
	Facility number Provider number AIM number: N	er: 005616						
	Survey Team: Laura Brashea Teresa Buske, Karen Hartman	RN						
	Census bed typ Residential: 87 Total: 87							
	Census Payor to Other: 87 Total: 87	type:						
	Sample: 11							
		dings are cited in h 410 IAC 16.2.						
	Quality review	completed on						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED 10/04/2013		
	ROVIDER OR SUPPLIER AT GARDEN PLAZA	STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
IAG	10/10/2013 by Brenda Marshall Nunan, RN	TAG	DEFICIENCY		DATE		

State Form Event ID: VULQ11 Facility ID: 005616 If continuation sheet Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
			B. WINC	j		10/04/	2013
			' Т	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				8614 W	10TH ST		
BRIDGE	AT GARDEN PLAZ	A		INDIAN	APOLIS, IN 46234		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000217	410 IAC 16.2-5-2						
	Evaluation - Defic						
		pletion of an evaluation,					
		appropriately trained staff					
		lentify and document the ovided by the facility, as					
	follows:	ovided by the facility, as					
		offered to the individual					
	` '	appropriate to the:					
	(A) scope;						
	(B) frequency;						
	(C) need; and						
	(D) preference;						
	of the resident.	offered shall be reviewed					
		propriate and discussed by					
		acility as needs or desires					
		e facility or the resident					
	may request a se						
		oon service plan shall be					
		by the resident, and a					
		e plan shall be given to the					
	resident upon req	•					
		on and documentation of list needed if evaluations					
		e initial evaluation indicate					
	no need for a cha						
		on of medications or the					
	provision of reside	ential nursing services, or					
	both, is needed, a	a licensed nurse shall be					
		ication and documentation					
	of the services to						
	Based on recor	-	R00	0217	R217: Responses to the cited		11/01/2013
		acility failed to provide			deficiencies do not constitute a		
	services accord	<u> </u>			admission or agreement by the provider of the truth of the fact		
	physician order	r frequency for 1 of 1			alleged or conclusions set forth		
	residents review	wed receiving dialysis.			the Statement of Deficiencies.		
	(Resident #38)	-			The Plan of Correction is		
	. ,				prepared solely as a matter of		
	Finding include	es:			compliance with Federal and		
					State Law. With Respect to the	9	

State Form Event ID: VULQ11 Facility ID: 005616 If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
		B. WIN			10/04/	2013	
		1	b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			10TH ST		
BRIDGE AT GARDEN PLAZA					APOLIS, IN 46234		
	BRIDGE AT GARDENT LAZA			<u> </u>	Al OLIO, IIV 40204		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	•		DATE
					Specific Residents Cited:		
	Upon review of	f Resident #38's clinical			Resident # 38 did not experier		
	record on 10/4	/13 at 1 p.m., a current			a negative outcome. Physicia follow up was conducted durin		
	physician's ord	ler dated, 4/21/13, of			the survey for order clarification	•	
		ood pressure] on			including Blood Pressure resu		
	_	ays and fax monthly to			communication. Physician		
	1	an specific name and			ordered blood pressures shall	be	
	phone number	•			recorded on the Medication		
	Priorie Hullinel	1.			Administration Record. With		
	Limas nasitati	£ 4h o moonatisti - tura atir t			Respect to How the Facility wi	II	
	•	f the monthly treatment			Identify Residents with the Potential for the Identified		
		y 2013, June 2013,			Concern and Take Corrective		
	, , ,	ıst 2013, September			Action: A review of the Physici	an	
	2013, and Octo	ober 2013, blood			Orders and Medication	u	
	pressure result	ts for non-dialysis days			Management Policies were		
	were incomple	te according to the			completed by the Resident Ca	re	
	physician's ord	ler frequency.			Director and Administrator. Ar		
	Documentation				audit of resident physician ord	ers	
		g.			was completed to ensure		
	The May 2013	treatment record			compliance. The Resident Ca Director will review New and	re	
	1	entation to indicate			Change Physician Orders.		
					Physician ordered blood		
	•	e monitoring for 2 of 17			pressures shall be recorded or	า	
	,	ays (5/7/13, and			the Medication Administration		
	5/19/13.)				Record. The 24-hour report a	nd	
					resident clinical record will		
		treatment record			indicate physician communica	tion	
	lacked docume	entation of completion			of ordered Blood Pressures. With Respect to What Syster	nic	
	of blood pressi	ures on non-dialysis			Measures have been put in pla		
	days for 7 of 1	7 days (7/13, 7/14,			to Address the Stated Concern		
		1, 7/27, and 7/28).			In-service training was provide		
		,			for Licensed Nurses and		
	The August 20	13 treatment record			Qualified Medical Assistants o	n	
	The August 2013 treatment record lacked documentation of completion				Follow Physician Orders and		
		ures on non-dialysis			MAR documentation complian		
	•	•			expectations. With Respect	(0	
	1	18 days (8/1, 8/3, 8/4,			How the Plan of Corrective Measures will be monitored Th	10	
	8/6, 8/8, 8/10,	8/11, 8/13, 8/15, 8/17,			Micasures will be monitored in	iC	

State Form Event ID: VULQ11 Facility ID: 005616 If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		î ´	E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00		PLETED 4/2013	
			B. WING			7/2013
NAME OF P	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZII	P CODE	
BRIDGE	AT GARDEN PLAZ	7A		V 10TH ST NAPOLIS, IN 46234		
				T		(25)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIO)		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	8/18, 8/20, 8/2	2, 8/24, 8/25, 8/27,		Resident Care Direc	tor will	
). The only blood		conduct weekly MAR compliance		
		orded were on 8/5/13,		d follow up will		
	and 8/12/13.			be reviewed during t Quality Assurance m		
	The Septembe	er 2013 treatment				
	record lacked	documentation of				
	completion of I	blood pressures on				
		ays for 2 of 17 days				
	(9/3, and 9/17)).				
	Upon interview					
		de (QMA) #1 on 10/4/13				
	-	ne QMA indicated				
		had hemodialysis on				
	•	nesday, and Friday.				
	The QMA state					
		ng the recorded blood				
	pressures to the	n of confirmation of				
		od pressures monthly to				
	the physician v					
	uie priysiciali v	was lacking.				
	Upon interview	v of the Administrator				
	•	on 10/4/13 at 2 p.m.,				
		the physician's office				
		of the blood pressures				
		he office. The QMA				
	_	physician preferred for				
	•	sures to continue to be				
	•	dialysis and then faxed				
	to his office.	,				
	5-2(e)(1)(B)					
	5-2(e)(1)(C)					l

State Form Event ID: VULQ11 Facility ID: 005616 If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
		B. WIN			10/04/	2013	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			/ 10TH ST		
PDIDCE		Λ.					
BRIDGE AT GARDEN PLAZA				INDIANAPOLIS, IN 46234			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000273	410 IAC 16.2-5-5						
		nal Services - Deficiency					
		ration and serving areas					
		in residents ' units) are					
		cordance with state and					
		nd safe food handling					
	standards, includi		DOG	00273	DOZO: Doonanaa ta tha aitad		11/01/2012
	Based on observation and interview,		KU	102/3	R273: Responses to the cited		11/01/2013
	•	d to provide safety of			deficiencies do not constitute an admission or agreement by the		
		or 1 of 1 kitchen			provider of the truth of the fact		
	observation in that items in dry				alleged or conclusions set fort		
	storage were expired or opened items				the Statement of Deficiencies.		
	requiring refrigeration remained in the				The Plan of Correction is		
	dry storage area. This had the				prepared solely as a matter of		
	potential to affect all 87 residents of				compliance with Federal and		
	the facility.				State Law.With Respect to the		
	the facility.				Specific Residents Cited: The		
					white vermicelli sprinkles with expiration date of 1/2/13 were	an	
	Finding include	: S.			removed from storage and		
					discarded. The two containers	s of	
		Il dietary tour with the			vanilla whipped cream cheese		
	FSD (food serv	vice director) on			frosting with an expiration date		
	10/3/13 at 11:3	55 a.m., the following			7/20/13 were removed from		
	were observed	in the dry storage area			storage and discarded. The		
	of the kitchen:	, 0			Daily's Sweet and Sour liquid		
					punch mix that was		
	a White Verm	nicelli Sprinkles that			unrefrigerated after opening w	as	
		•			removed from storage and		
	nad an expirati	on date of 1/2/13.			discarded. The Nutella spread		
					with an expiration date of 7/28 was removed from storage and		
		ers of Vanilla whipped			discarded. With Respect to Ho		
	cream cheese	frostings with			the Facility will Identify Reside		
	expiration date	s of 7/2013.			with the Potential for the Identi		
					Concern and Take Corrective		
	c. Dailv's Swee	et and Sour liquid			Action: A review of the Produc	ct	
	•	oz. container opened			Rotation, & Refrigerator Storage	ge	
	•	re's directions to			policy was completed by the		
					Dining Service Director &		
	refrigerate afte	i opening.			Assistant Dining Service		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00		COMPLETED
			B. WING		10/04/2013
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	8		/ 10TH ST	
BRIDGE	AT GARDEN PLAZ	ZA .		IAPOLIS, IN 46234	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
IAU	d. A container oz , with a mar date of 7/28/13 On 10/3/13 at a interviewed. T	of Nutella spread, 26.5 nufacture's expiration 3. 1145 a.m. the FSD was he FSD indicated he onsible for checking	IAG	Director. The Dining Service Director/Designee will conduct daily random monitoring to rev food expiration and storage compliance. The process for ensuring follow up and compliance checks was established.With Respect to What Systemic Measures hav been put in place to Address t Stated Concern: In-service education has been scheduled the kitchen associates to reviet food expiration and refrigerate storage compliance policies, procedures and expectations. With Respect to How the Plan of Corrective Measures will be Monitored: Dining Service Director/Design will perform random compliance follow up daily for 30 days and report findings to the Administrator weekly. Randor compliance audits will then be completed and a monthly review will be made by the FSD to the administrator regarding randor round compliance findings and follow up. Findings will be reviewed and follow up during monthly QA meetings.	e he d for ew or of the nee ce d m ew e m d

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